



**EVALUATION
OF THE
ENRICH PROJECT
IN THE
AUTONOMOUS REGION OF MUSLIM MINDANAO (ARMM)
EXECUTIVE SUMMARY**

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ACRONYMS

AED	Academy for Educational Development
ARMM	Autonomous Region of Muslim Mindanao
BCC	Behavior change communication
CA	Cooperating agency
CCF	Christian Children's Fund
CDLMIS	Contraceptive delivery logistics management information system
CHD	City Health Department
DOH	Department of Health
DOTS	Directly observed therapy, short course (for tuberculosis)
EnRICH	Enhanced and Rapid Improvement of Community Health
FHSIS	Field health services information system
FP	Family planning
HFC	Healthy Family Coalition
HKI	Helen Keller International
IEC	Information, education, and communication
KAP	Knowledge, attitudes, and practices
LEAD	Local Enhancement and Development for Health project
LGU	Local government unit
NDHS	National Demographic and Health Survey
NGO	Nongovernmental organization
NTP	National Tuberculosis Program
PVO	Private voluntary organization
SCF	Save the Children Federation, Inc.
SO	Strategic Objective
TBA	Traditional birth attendant
TSAP	The Social Acceptance Project
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

The Autonomous Region of Muslim Mindanao (ARMM), a poverty-stricken region of the Philippines, represents only 13 percent of the total Philippine population but registers the country's lowest family planning and health statistics, well below national averages. It is not yet clear if the high growth rate of 3.86 percent (National Demographic Health Survey [NDHS] 2003) can be averted when only 11 percent of couples accept and use modern contraceptives, and government efforts are severely limited and compromised with continuing unrest, political instability, and the sheer difficulty in reaching many remote populations.

Health indicators in the ARMM are alarmingly low. For example, vitamin A deficiency is most severe, with vitamin A supplementation coverage of 50.5 percent (6–59 months); the national average is 76 percent. Full immunization coverage is 44 percent (12–23 months); the national average is 70 percent. Only 50 percent of mothers are receiving health professional–assisted antenatal care, against a national average of 88 percent (National Demographic and Health Survey [NDHS] 2003). It is felt that unless continuous, concerted, and highly focused assistance is provided, the region will continue to deteriorate.

Many claim that the promise for improved governance through ARMM's autonomous status has yet to be realized. There are many who believed that conditions were better off under the previous arrangement, in which the provinces reported to the Department of Health (DOH) regional offices. The current leadership in the region is not trusted because of perceived apathy and lukewarm responsiveness to the health needs of the people. In addition, the national government's ability to respond is reduced in respect for the ARMM's autonomous status.

The regional office indicated that a complex administrative structure is part of the problem. There are five provinces in the ARMM (Maguindanao, Lanao de Sur, Sulu, Tawi-Tawi, and Basilan) and one city (Marawi). Isabela City is in the island province of Basilan but is not included in the ARMM. Cotabato City is outside of the geography of the ARMM but is the seat of the ARMM regional government. This creates confusion in terms of budgeting, resource allocation, and priority setting, and further reduces the jurisdiction and effective governance of the regional office. Furthermore, there are other legitimate issues to consider. The limited budgetary allocation (ARMM has no maintenance, operating, and other expenses budget, unlike other regions) and the unclear roles and responsibilities of regional, provincial, and local governments further weaken the administrative capacity of the region. Unifying the ARMM population, which is already divided not only geographically but by tribal affiliation, adds to the challenge.

The United States Agency for International Development (USAID), recognizing the situation in the ARMM, has provided technical and funding assistance to alleviate the population's general health status. In September 2002, USAID launched the Enhanced and Rapid Improvement of Community Health (EnRICH) project. Four U.S. private voluntary organizations (PVOs), with \$2.8 million in funding assistance, were engaged to form and mobilize community organizations, develop strong multisectoral linkages,

improve the clinical skills of health workers, and expand the delivery of health services in selected municipalities of four of the five ARMM provinces (except Maguindanao).

Much has been accomplished over a short period of 18 months. For example, as of March 2004, a total of 17,207 new family planning acceptors for modern methods have been achieved in the four provinces of the ARMM (Lanao del Sur: 6,775; Basilan: 1,256; Sulu: 1,248; and Tawi-Tawi: 7,928). A total of 647 tuberculosis smear positives were detected and treatment was started in the three provinces (Basilan: 110; Sulu: 286, and Tawi-Tawi: 251). Helen Keller International (HKI) has reported a dramatic increase in vitamin A coverage of children under 5 from 78.8 percent in 2002 to 86.2 percent in 2003.¹ A similar trend was also visible for immunization coverage.

Before EnRICH, family planning (FP) and tuberculosis program coverage were virtually nonexistent due to DOH budgetary limitations. The ARMM budget covered only salaries, and there was no allocation for family planning and health program expenses. For grantees to achieve this level—considering major program limitations—is remarkable. In fact, the project may have been able to show additional results if the ARMM had reliable baseline information.

One of the most remarkable achievements is the success in forging truly multisectoral community organizations, with the active participation of the provincial government, Muslim religious leaders, key barangay leaders, and volunteer health workers working collaboratively to provide for the health needs of the community members. The fact that the motivations of the members are not based on monetary considerations presents a strong argument for sustainability. Civic duty and a sense of ownership appear to be the driving forces for cooperation. Strong community organizations not only complement the government's efforts in strengthening service delivery points (rural health units and barangay health stations), but are essential for ensuring sustainable development. Now, the burden of providing health coverage becomes a shared responsibility of the community and government.

The grantees have developed many variations in the formation of community groups. HKI formed barangay health teams in Lanao del Sur, Christian Children's Fund (CCF) organized community health committees, ACDI/VOCA composed healthy family coalitions, while the Save the Children Federation, Inc. (SCF) formed barangay health teams and barangay health committees. CCF and ACDI/VOCA, recognizing the strength of community organizations, formed and registered them with the Securities and Exchange Commission as a way of protecting their interests and using their legal personality as a way to access additional support from other government entities and donor groups. HKI and SCF are currently working on a similar registration process. There is a need to document best practices to facilitate replication and expansion of strategies in other municipalities of the ARMM.

Another outstanding achievement of the grantees is their advocacy efforts among Muslim religious leaders. Many key religious leaders (imams and ustadz), who earlier posed major resistance to family planning, have not only become converts but were also transformed into active spokespersons for family planning using the fatwa. Currently,

¹ Grantees derived their data from cluster surveys conducted in early 2003 and may vary from such national indicators as the NDHS.

family planning topics are increasingly included during Friday sermons in the mosque. The use of observation study tours for Muslim religious leaders has proven to be effective in changing attitudes and behavior. Continuing this effort and expanding it across other segments of the ARMM population will strengthen advocacy.

While the improvements in the delivery of health services are visible in the communities covered by the grantees, not all were able to benefit from it. EnRICH covers 340 of 1,897 barangays (18 percent) in the four provinces of the ARMM (except Maguindanao) due to resource limitation, geographic inaccessibility of many municipalities, and the prevailing peace and order situation in many areas posing serious security risks to project staff and community workers.

Project accomplishments, while substantial, are still insufficient to create a positive impact on the regional or national health indicators. The limited timeframe (two years) further reduced by implementation problems was not sufficient to enable grantees to complete the intervention. Many grantees are still in the midst of implementation, and time has expired.

The effective monitoring of project performance presented a major difficulty, not only for the grantees but also for the region, given the absence of reliable baseline data and the corresponding reliable and uniform health information systems maintained at the regional level. NDHS data, while limited in representing the geographic differences among the provinces, remains the most reliable source of information. Some provinces that maintain field health services information systems (FHSIS) and contraceptive delivery logistics management information systems (CDLMIS) may be able to provide a more accurate profile, but not all provinces are doing so. Furthermore, the mobile population of the ARMM and the number of tribal and remote populations there has rendered data collection extremely difficult. Additional efforts are needed to develop a uniform information and monitoring system that truly represents the geographic differences of the region.

Other outstanding strategies implemented by grantees in the ARMM include the

- use of radio for distance learning, effective for reaching a wide audience with health messages and improving the general knowledge and clinical skills of health workers;
- use of a floating clinic as a way to reach remote populations not accessible by land transportation;
- provision of contraceptives and other essential drugs (such as tuberculosis treatments) when commodities became unavailable;
- construction of service delivery points (barangay health stations) in areas where they are most needed, particularly when government resources and political will are limited;
- implementation of numerous skills training sessions to upgrade the skills of health workers;

- provision of small operating expenses to facilitate area coverage;
- implementation of observation study tours for Muslim religious leaders to strengthen advocacy;
- lobbying for provincial health office support for drugs when commodities are limited; and,
- ability to be flexible (grantees and donors) and quickly respond to changing needs, despite the restrictions imposed under the current cooperative agreements.

RECOMMENDATIONS

Continue the EnRICH project and expand it geographically. Two years is too short to realize a meaningful impact in family planning acceptance and the effectiveness of health interventions. The continuing disruptions caused by the peace and order situation, geographic distance and inaccessibility of many areas, and the difficulty in fielding project staff have further reduced the productive implementation time of the project. Most grantees are only in the midst of implementation, and time has expired. New start-up efforts will affect the momentum and continuity of implementation. It is strongly suggested that a timeframe similar to other project funding cycles (five years) be provided to the follow-on EnRICH project. The current 24 percent project coverage of selected municipalities in the ARMM is limited in achieving a significant impact on both regional and national indicators. While it is understood that there are still many municipalities where coverage is virtually impossible and risky, grantees have already identified some where conditions are conducive. The provisional health offices have identified these municipalities and the local chief executives have expressed a readiness to implement the project.

Expand project components. The improvement of health conditions in the community requires an integrated approach. While current strategies are based on greater need given the resource limitations, the overall effectiveness of the strategy is weakened when certain needs of the population are not addressed. The implementation of four additional project components is recommended.

- **Adolescent reproductive health:** While data are limited, adolescent reproductive health is recognized as one of the unmet needs in family planning. There are currently no services available to adolescents. Studies show that adolescent needs for FP are equally important and need to be addressed. SCF has recognized this as a gap in its program, and has included it in its future plans.
- **Functional literacy program:** This program is specifically intended for females. Where female literacy is low, the ability of the program to reach women with FP and health messages will be limited. Awareness will continue to be low, and empowering women will be an arduous task.

- **Disaster relief and preparedness of the community:** Grantees believe that the state of readiness is low, as are the response capabilities of communities to impending disaster. In the event of a regional or national disaster, the less-prepared communities would suffer and have the hardest time coping.
- **Livelihood projects:** Achieving sustainability will be difficult unless communities achieve economic self-reliance. A majority of ARMM communities are poverty stricken. Opportunities and resources are severely limited. The cycle of poverty, despondency, and dependence is difficult to break when communities do not have an economically viable livelihood. There is a need for assistance on income-generation projects, particularly for communities that have already organized themselves into community enterprises. To enable these communities to continue their path to self-reliance, technical assistance and an enabling environment have to be provided. Activities under this component may include livelihood skills development, marketing assistance for local products, and entrepreneurial training. The needed technical expertise may be drawn from some of the grantees that are already providing this kind of assistance in their current program.

Expand implementation of advocacy to Muslim religious leaders using the fatwa.

Grantees have demonstrated their effectiveness in reducing religious resistance to family planning through their advocacy efforts focused on key Muslim religious leaders. However, their advocacy efforts have only been implemented in a few selected municipalities covered under the project. Religious resistance in many nonproject sites is still strong and will remain strong unless Muslim religious leader advocacy efforts are expanded to these areas and are uniformly implemented across the ARMM. The grantees should expand the promotion of the fatwa to other nonproject sites. Intensified efforts should be made with conservative Muslim religious leaders to gain their acceptance and endorsement of FP. Grantees should uniformly promote the use of Muslim religious leaders as advocates or spokespersons for FP. Grantees should also explore the use of highly placed religious leaders (grand mufti) to conduct advocacy among conservative Muslim religious leaders.

Use observation study tours for Muslim religious leaders. The project should continue the implementation of regional observation study tours for Muslim religious leaders to facilitate the sharing of information, strengthen support for advocacy, and unify all Muslim religious leaders towards the promotion of family planning.

Organize a Muslim religious leader advocacy group. Grantees should organize Muslim religious leaders into an active advocacy body to promote adherence to the fatwa among members, hold regular discussions, and develop uniform health and family planning messages, particularly during Friday sermons in the mosque.

Negotiate a discussion between the ARMM, provincial governments, and local government units (LGUs). It is apparent that the level of communication between the ARMM, provincial government, and LGUs is low. Regional work plans will be limited and less effective if participation of other key government leaders is nonexistent. It is particularly important that the process and venue for regular discussions are provided,

especially when the resources from the province and LGU are critical for supporting the delivery of services.

Develop a physical distribution system for commodity and essential drugs. FP will not prosper without commodity support. The frequent stock outages will constrain acceptance. A mechanism should be developed where commodities are shipped directly by the supplier to the destination province. This will reduce the transportation cost and at the same time expedite the shipment. Transportation costs should also be equally shared by the region, province, and LGU to widen the resource base.

Implement a health facility assessment and regional health information system. The project should engage an independent body to implement a health facility assessment for the ARMM. The health facility assessment should include the establishment of baseline data for basic health indicators and the development of a reliable health information monitoring system for the region. Measurements of performance should be done by the independent body at regular intervals.

Concentrate in key expertise areas. While grantees have performed well with all components under their charge, their achievements in their areas of expertise are outstanding. This comparative advantage needs to be optimized, and will require their concentration in their competency areas. However, a mechanism needs to be established wherein expertise is provided to grantees in areas where it is lacking, particularly during the formation of strategies. Grantees should also access available expertise within their organization (or elsewhere) to ensure a high level of competence.

FUTURE PROGRAM FOCUS AND NEXT STEPS

The follow-on project should focus on maintaining that which has been achieved. Best practices should be replicated and implemented in the ARMM's other geographic areas. Additional efforts should be made to create a mechanism that will foster a regular discussion among the key government leaders of the region, province, and LGU. The long-term solution to the problem lies in the strong collaboration of these bodies in the programming and sharing of resources in developing the ARMM and the eventual adoption of the project by the LGUs.

The development of baseline indicators should begin early in the next phase of EnRICH implementation. The strategy and components of the follow-on project should also be designed early, building on the project's prior accomplishments to ensure seamless project implementation.

CONCLUSION

The EnRICH project has set the stage and framework for the follow-on project. Grantees have successfully formed and empowered strong community organizations. There is evidence that these community organizations, operating under the power of volunteerism, will stay for the long term and be the best instruments for sustained development. Grantees have also demonstrated their tenacity for performing under the most difficult circumstances and security risks. Best practices have been identified from the multiple strategies implemented to achieve the desired health outcome. Political and

administrative challenges have also been identified, and solutions have been developed to address them. The winning strategies will now provide the foundation upon which to build. However, grantees still need additional time to complete what they have begun. The time provided was too short to enable the achievement of meaningful results. ARMM needs the EnRICH project to complete its development. The project needs to continue and expand to other ARMM geographic areas not yet reached. The lives saved and the health of mothers and children improved are more than commensurate returns on investment.



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